

**HACKETTSTOWN REGIONAL MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL**

PAIN MANAGEMENT

Effective Date:	08/2004	Policy No:	PC28
Cross Referenced:		Origin:	Patient Care Services
Reviewed Date:	7/14, 2/16	Authority:	Chief Nursing Officer
Revised Date:	03/08, 06/11, 7/14, 2/16	Page:	1 of 13

PURPOSE:

To assure that patients will have access to the safe and effective management of pain.

To establish guidelines to prevent, assess, diagnose, treat, and reassess the acute and/or chronic pain management needs of patients

DEFINITIONS:

Pain: An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is highly personal and subjective and is whatever the patient says it is, existing whenever he/she says it does. Self-report of pain is considered the most reliable indicator of pain.

Acute Pain: A normal, predicted physiologic response to tissue/organ damage or disease. It is generally time-limited, and is responsive to opioid and non-opioid medications. Note: Acute pain episodes may be present in patients with chronic pain.

Chronic Pain: Malignant or non-malignant pain that does not resolve during the acute phase and persistent pain beyond expected recovery intervals or remains present because of the disease or injury. It is persistent pain that is not amenable to routine pain management. Note: Patients with chronic pain may have episodes of acute pain related to treatment, procedures, disease progression or reoccurrences.

Pain Management: Use of pharmacological and non-pharmacological interventions to control the patient's pain. Pain management extends beyond pain relief, encompassing the patient's quality of life and ability to work productively and enjoy recreation.

Pain Screen: A quantitative reading of the intensity of pain as reported by the patient utilizing a standardized instrument (i.e., Numeric 0-10 Scale, Wong-Baker Faces) that has demonstrated reliability and validity. The Hierarchy of Pain Assessment Techniques should be utilized if the patient is unable to give self-report.

Pain Assessment: An evaluation of the cause of the patient's pain may include, but is not limited to : location of the pain, description of the pain, intensity, aggravating and alleviating factors, associated signs and symptoms, impact on functional ability, sleep patterns, psychosocial, aspects of the patient's life and effectiveness of current/past pain management strategies, and the patient's personal goal for pain management. The pain assessment includes the rating from the pain screen or observation, or the clinician's utilization of the Hierarchy of Pain Assessment Techniques.

Multi-modal Balanced Analgesia: the use of combined analgesic regimens, which allow lower doses of each analgesic, thereby producing fewer significant adverse effects and achieving comparable or better pain relief than is possible with any single analgesic (Pasero, 2003).

POLICY:

All patients treated at HRMC have the right to effective and safe pain management. HRMC is committed to providing patients with a plan devised in a collaborative manner, utilizing the strengths of the entire health care team, as well as the patient and their family whenever possible.

Approved at President's Council meeting 2/1/2016

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PROCEDURE:

I. Pain Assessment

- A. All patients will be assessed for the presence of pain, in both the inpatient and outpatient settings.
1. The patient's self-report is the best indicator of the presence, intensity and nature of pain.
 2. HRMC staff will use the following age categories as *general guidelines* when selecting the most appropriate pain assessment scales and tailor the selection to the patient's unique stage of growth and development. **(SEE APPENDIX FOR SPECIFIC EXAMPLES).**
 - a. The **Numerical Rating Scale (NRS)** will be utilized for most patients. The NRS is the most reliable scale and easiest to score and record. HRMC uses a 0-10 NRS. Studies suggest that patients be shown a visual of the scale (Pasero & McCaffery, 2011).
 - b. For patients who are unable to provide a self-report of pain (unable to count or understand the numerical component of the NRS), the 10-point **Wong-Baker FACES Pain Rating Scale** will be used to assess pain at baseline and after treatment or analgesics to determine the effectiveness of the intervention. Patients unable to rate pain verbally (e.g., ventilator patients) may be able to indicate their level of pain on the Wong-Baker FACES Pain Rating Scale by pointing to the level of pain on the numeric scale.
 - c. The 10-point **Adult Behavioral Pain Scale (ABPS)** will be used to assess pain for cognitively impaired patients (generally over 7 or years of age), or other patients (school age through adult) who are unable to give a self-report of pain. Patients who cannot provide a verbal self-report of pain due to communication problems or cognitive impairment will be directly observed for pain behaviors.
 - d. The 8- point **Critical Care Observation Pain Tool (CPOT)** can be used to assess pain for cognitively impaired adult patients in a critical care setting who are unable to give a self-report of pain and/or are intubated.
 - e. The 10-point **FLACC Scale** will be used to assess pain for children (generally 1 months-7 years old). Manifestations of pain behavior including facial expressions (grimacing, frowning), vocalization (shouting, moaning), body movements (pacing, rocking), protecting a body part, and mental status changes (increased confusion, new agitation) are to be used to assess a patient's pain when using the FLACC Scale.
 - f. Neonates and infants (birth up to one month) will be assessed for pain using the 7-point **Neonatal Infant Pain Scale (NIPS)**.
 3. All patients will be assessed for intensity of pain and their acceptable level of pain intensity using an objective rating scale. If the patient confirms current or recent pain at the time of the initial assessment, the following will be documented in the patient's medical record:
 - a. Location of the pain;
 - b. Pain intensity/severity (using the point scale specific to the assessment tool);
 - c. Type/quality of pain (sharp, dull, aching, burning);
 - d. Duration of pain (intermittent or constant);
 - e. What helps (alleviates) the pain; and
 - f. What (exacerbates) makes the pain worse.

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4. Patients may need to be awakened for assessment and assessed for pain if they have a positive pain assessment and require pharmacological intervention.

5. Prior to discharge home:

- a. Patients who have received any analgesic medication which they have not taken previously should remain in the outpatient/inpatient area for 30 minutes following administration to observe for signs of adverse reactions.
- b. Every reasonable attempt should be made to prevent patients who have received sedating medication from driving a vehicle.
- c. If a patient is requested to remain in the outpatient/inpatient area and refuses, follow the AMA (Against Medical Advice) policy.

B. Frequency of pain assessment/reassessment will be done at the following intervals:

1. Inpatient:

a. Assessment

- i. An initial assessment of pain will be conducted by the RN upon admission
- ii. If the patient does not have any pain, assessment should be done at least every 24 hours.
- iii. A pain assessment will be done with each *new* report of pain, unrelieved, or worsening pain, significant changes in patient's condition, and prior to transfer to another level of care or discharge (added this from reassessment section)
- iv. Pain will be assessed after any known pain producing event. Specific protocols and procedures will define the interval of assessment.

b. Reassessment

- i. The patient is periodically assessed / reassessed for pain, relief from pain, and response to treatment at regular intervals at a minimum of once a shift
- ii. Nursing staff members ask patients about their comfort and pain level on rounding
- iii. The frequency of pain reassessment is dictated by the intensity of the patient's pain, the method of pain relief used and the effectiveness of pain relief strategies. i.e. post operative pain
- iv. The post intervention (non-pharmacological or pharmacological) reassessment should be performed according to the intervention.
- v. The reassessment post intervention should not exceed more than two hours.

2. Emergency Department/Surgical Services

a. Initial assessment of pain will be conducted by the Registered Nurse upon the patient's arrival (during the triage process/pre-operative assessment).

b. Following the initial pain assessment, patients will be reassessed for pain:

- i. Within one hour of a pharmacologic or non-pharmacologic intervention or treatment being provided to relieve pain.
- ii. With each *new* report of pain, unrelieved, or worsening pain.
- iii. According to patient's condition; during routine vital signs as warranted; and at discharge, transfer to another facility or admission to inpatient care.

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3. Outpatient Areas-Diagnostic/Radiation Therapy/Speech Therapy:
 - a. A pain screen should be done at the time of presentation to the diagnostic area.
 - b. Patients with a positive pain screen will either be treated in the outpatient area or referred for appropriate treatment (primary physician, ED, etc.) according to need or patient request.

4. Outpatient Areas-Wound Healing Center/Infusion Center/Rehab Services other than Speech Therapy:
 - a. An initial assessment of pain will occur at the time of presentation to the area.
 - b. Patients with pain will either be treated in the outpatient area or referred for appropriate treatment (primary physician, ED, etc.) according to need or patient request.
 - c. During subsequent outpatient visits, patients will be reassessed for pain.

II. Pain Interventions

A. Initiate interventions for pain relief (comfort measures or medicate as ordered).

1. Utilize the HRMC “Analgesia Based on Intensity of Pain” guidelines when administering analgesics based on mild, moderate or severe pain as described by the patient.

HRMC Analgesia Based on Intensity of Pain
(approved by the Medical Executive Committee)

MD ORDER FOR	ON 0 – 10 SCALE	CPOT Scale
Mild Pain	Pain Scale 1 – 4	1-2
Moderate Pain	Pain Scale 5 – 7	3-5
Severe Pain	Pain Scale 8 - 10	6-8

2. Focus intervention on achieving and maintaining a steady level of analgesia/pain control utilizing around the clock (ATC) dosing whenever possible.

3. If performing treatments or procedures that are painful and the patient is sedated or otherwise unable to report the presence of pain consider the use of pre-emptive analgesia.

4. **Any of the following** will indicate the need for a review of the current pain management plan and intervention to improve the patient’s relief of pain or referral to the appropriate provider or setting for treatment:
 - a. A score of greater than 3 out of 10 (>3/10) using the NRS, Wong-Baker FACES Pain Rating Scale, ABPS, or FLACC scales
 - b. A score of greater than 3 out of 7 (>3/7) using the Neonatal Infant Pain Scales (NIPS) or 3 out of 8 (>3/8) using the Critical Care Pain Observation Tool (CPOT)
 - c. The patient’s complaint of inadequate relief of pain will indicate the need for a review of the current pain therapy and intervention to improve the patient’s relief of pain or referral to the appropriate provider or setting for treatment. This should be done after all appropriate medications have been administered and reassessment of their pain level has been accomplished. Include the patient’s report of pain and their level of functioning when notifying the physician/provider.

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5. Assess the patient frequently for untoward side effects of opioid use:

Symptoms often associated with opioid administration include nausea/vomiting, constipation, respiratory depression, hypotension, urinary retention, pruritis, and sleepiness.

Respiratory depression and/or arrest can occur with narcotic agents as well as with barbiturates, midazolam, diazepam, and lorazepam, particularly when these agents are given in combination.

Assess for these symptoms frequently and intervene as appropriate. If there are no orders to manage these side effects, notify the physician for appropriate orders.

B. Policies and procedures for advanced pain control techniques (including intravenous and epidural PCA) as well as specific procedural pain management will define the acceptable level of patient monitoring. These policies will also define roles and responsibilities of staff (including competencies, program(s) for education, and periodic updating and accountability). Note: for analgesia in mechanically ventilated patients, please refer to Pharmacy/Nursing Policy PN.004a.

C. Patient's pre-hospitalization analgesic and/or pain control method(s) will be incorporated into the plan of care when applicable

D. Pharmacological Interventions (for Postoperative Pain Ladder see APPENDIX)

1. Non-opioid analgesics

i. Acetaminophen

- Useful and safe for mild to moderate pain
- Minimal anti-inflammatory effect

ii. NSAIDS: parenteral therapy is effective in post-operative acute pain

- Very safe, no ventilatory depression or acute hemodynamic effects
- Useful in post-operative pain, inflammatory, or rheumatologic conditions

2. Opioid analgesics

- Mainstay of analgesia in the treatment of moderate to severe pain in patients of all ages
- Overwhelming fears of respiratory depression and physical addiction continue but are unfounded.
- Common side effects – constipation, sedation, pruritis, nausea/vomiting
- Consider a bowel regimen to include stool softener/laxative
- For the non-surgical patient, a pain management plan of care should be instituted to decrease tolerance and provide the patient with attentive analgesic care.

3. Anesthetics

Local anesthetics block the generation and conduction of nerve impulses in a specific area of the body. The pH of undiluted anesthetics such as lidocaine may cause pain on injection. This effect may be reduced by mixing lidocaine with a sodium bicarbonate solution. A local anesthetic should be considered prior to a procedure that is known to be very painful such as chest tube placement. Local anesthetics to consider include but are not limited to:

- Lidocaine 0.5%
- Lidocaine 1%
- Eutectic Mixture of Local Anesthetic (EMLA)

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III. Patient/Family Education

A. Inpatients and outpatients will receive instructions regarding pain management including when and how to contact health care provider to request interventions for comfort/symptom relief. Patients will be informed at the time of initial evaluation that effective pain relief is an important part of their treatment. Information will specify that health care providers will respond promptly to their complaint of unrelieved pain (attentive analgesic care). It will also be made clear to patients and families that the total absence of discomfort may not be a realistic goal.

B. Discharge planning should start with the patient as soon as possible. Evaluate the effectiveness of the pain medication that the patient is given and assess for side effects. If the patient is receiving IV medications, discuss conversion to oral or transdermal route with the physician. Determine, as early as possible, the medication the patient is to be discharged on, so they can be converted to an equianalgesic dosage of the medication.

PEDIATRIC PAIN MANAGEMENT (Age 1 month to 17 years)

I. Pain Assessment: See Appendix A (*If age appropriate, the NRS or Wong-Baker scales may be used*)

A. The child will demonstrate physical activities that can be used to assess pain using the FLACC scale.

B. Younger children experience higher levels of pain during procedures than older children.

C. Children may not be able to express their pain in the same manner as adults. With the proper use of pain assessment scales, children as young as 3 years of age can use pain scales accurately.

D. Children exposed to repeated painful procedures often experience increasing anxiety and perception of pain with repeated procedures. School aged children and adolescents can report intensity, quality and location.

E. Children may not report pain due to fear of injections or hospitalizations.

F. An ongoing open dialog between staff and parents about pain is encouraged in the hope that increasingly accurate assessments will occur.

II. Interventions

A. Non-Pharmacologic Interventions

1. Distraction
 - Looking at books
 - Blowing bubbles
 - Counting

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- Touch
- Deep breathing

- 2. Muscle Relaxation
 - Relaxation of voluntary muscles
 - Attention to breathing
 - Promote relaxation prior to anxiety producing procedure

- 3. Guided Imagery
 - Focus on pleasant activity
 - Give the child opportunity to be in a more pleasant situation
 - Effective use of imagery involves all the senses

- 4. Comfort Measures
 - Quiet
 - Presence
 - Massage
 - Music

B. Pharmacologic Interventions

A. Non-opioid analgesics

1. Acetaminophen

- Useful and safe for mild to moderate pain
- Most common non-opioid used in children
- Minimal anti-inflammatory effect

2. NSAIDS

- No ventilatory depression or acute hemodynamic effects
- May be utilized for post-operative pain, inflammatory, or rheumatologic conditions
- Use for children > 4months of age. Dosing is commonly every 6-8 hours.

3. Opioid analgesics

- Mainstay of analgesia in the treatment of moderate to severe pain in patients of all ages
- Overwhelming fears of respiratory depression and physical addiction continue
- By 3-6 months, infants are no more susceptible to respiratory depression than adults
- Infants less than 6 months should be monitored for apnea
- Common side effects – constipation, sedation, pruritis, nausea/vomiting

4. Anesthetics

Local anesthetics block the generation and conduction of nerve impulses in a specific area of the body. The pH of undiluted anesthetics such as lidocaine may cause pain on injection. This effect may be reduced by mixing lidocaine with a sodium bicarbonate solution. A local anesthetic should be considered prior to a procedure that is known to be very painful such as chest tube placement. Local anesthetics to consider include but are not limited to:

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- Lidocaine 0.5%
- Lidocaine 1%
- Eutectic Mixture of Local Anesthetic (EMLA)

NEONATAL PAIN MANAGEMENT (Age birth to 1 month)

I. Pain Assessment: See Appendix

- A. The ability to experience pain is present from as early as 10 weeks gestation.
- B. Pain is a subjective experience that cannot be communicated verbally by the infant.
- C. The infant will demonstrate physical activities that can be used to assess pain using the Neonatal Infant Pain Scale (NIPS).
- D. All attempts will be made to minimize pain during and after potentially painful procedures using nonpharmacologic/pharmacologic interventions as appropriate. Upon reassessment, if ineffective, call the provider for further intervention/treatment.

II. Non-Pharmacologic Interventions

A. Nonnutritive sucking

Nonnutritive sucking has been associated with a reduction in crying time and an increase in quiet alert behavior during and after painful procedures such as heelstick and circumcision. It has also been noted that premature cessation of nonnutritive sucking may result in an exacerbation of crying and tachycardia. Pacifiers utilized for nonnutritive sucking should be inspected for safety prior to use.

Nonnutritive Sucking should be:

- Initiated 2-5 minutes prior to a potentially painful procedure
- Maintained during any potentially painful procedure
- Maintained after the procedure until infant has a NIPS score of ≤ 3 .

B. Swaddling/facilitated tuck

The use of swaddling and facilitated tuck has been associated with cessation of crying, and faster return to pre-procedure heart rate. Facilitated tuck is the hold of an infant's extremities in a position of flexion close to the infant's trunk. A facilitated tuck may be done with a caretaker's hands or the use of positioning aides. Swaddling holds an infant's extremities in a position of flexion close to the infant's trunk using a blanket or cloth.

Swaddling/Facilitated tuck should be:

- Maintained during any potentially painful procedure.
- Maintained after the procedure until the infant has a NIPS score of ≤ 3 .

C. Transcutaneous strategy

Infant touch and massage may be used to distract the infant and decrease pain impulses.

Touch should be:

- Firm. Multiple light strokes may overstimulate an infant.
- Applied to the area to experience the procedure to desensitize the skin and expose the infant to a positive touch pre-procedure.
- Applied to the area after the procedure to re-inforce that not all touch is negative.

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III. Pharmacologic Interventions

- Require a physician's order
- Must take into account the patient's weight, renal function and hepatic function on drug dynamics.
- Medications may be administered prior to/during/or after painful procedure

A. Analgesics

Reduce the effect of noxious stimuli without loss of consciousness. Analgesics to consider include but are not limited to:

- Acetaminophen

B. Sedatives

Induce relaxation, decrease irritability and have a calming effect. Sedation has a role in the care and comfort of a neonate. However, sedation should not be used in place of an analgesic. Sedatives given without analgesia may increase excitement in an infant experiencing pain.

C. Anesthetics

Local anesthetics block the generation and conduction of nerve impulses in a specific area of the body. The pH of undiluted anesthetics such as lidocaine may cause pain on injection. This effect may be reduced by mixing lidocaine with a sodium bicarbonate solution. A local anesthetic should be considered prior to a procedure that is known to be very painful such as chest tube placement. Local anesthetics to consider include but are not limited to:

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SUPPORTIVE DATA:

- The single most reliable indicator, “the gold standard” of the existence and intensity of pain is the patient’s self-report (McCaffery and Pasero, 2011).
- All patients with pain may not experience all-encompassing pain relief, however, they should expect “attentive analgesic care”.
- The appropriate pain measurement scale will be instituted on each patient who presents with pain.
- In patients who are unable to self-report pain, other measures must be used to detect pain and evaluate interventions. No single objective assessment strategy, such as interpretation of behaviors, pathology, or estimates of pain by others, is sufficient by itself. Consider using a hierarchal approach to identifying the presence of pain in non-verbal patients. (Pasero and McCaffery, 2011).
- Patients can sleep with severe pain and sleep or sedation may be mistakenly equated with lack of pain (Pasero and McCaffery, 2011).
- Cognitively impaired or acutely confused older adults who can communicate can report pain if given a simple explanation and asking if “they hurt anywhere”.
- Search for potential causes of pain giving attention to pathologic conditions and common problems or procedures known to cause pain (e.g., surgery, wound care, rehabilitation activities, positioning/turning, blood draws, a history of persistent pain) should trigger an intervention, even in the *absence* of behavioral indicators.
- A change in behavior requires careful evaluation of the possibility of additional sources of pain. Generally, one may assume pain is present, and if there is reason to suspect pain, an analgesic trial can be diagnostic as well as therapeutic (APS, 2003, Pasero and McCaffery, 2011).
- Whenever possible, pain management should include an around-the-clock, multi-modal approach individualized to the patient.

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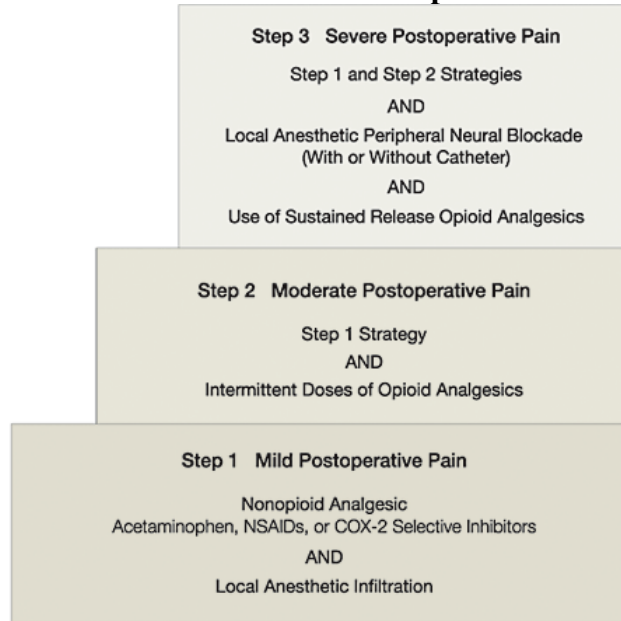
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APPENDIX

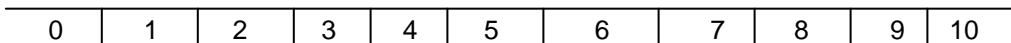
Pain Ladder for Acute Postoperative Pain



~From the World Health Organization

Numeric Rating Scale (NRS)

This scale is for assessment of pain in the patient population who are capable of rating their pain according to a numerical rating scale of 1 to 10.



No Pain

Worst Pain Imaginable



Wong Baker FACES Scale (Wong, D. & Baker, C. 1988)

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Adult Behavioral Pain Scale (ABPS)				
This scale is used for the assessment of pain on the cognitively impaired patient. Each of the categories is scored from 0 – 2 with a total score ranging from 0 (no pain) to 10 (worst pain).				
Indicator	0	1	2	Score
Emotion	Smiling	Anxious/Irritable	Almost in tears	
Movement	None	Restless, slow decreased movement	Immobile, afraid to move	
Verbal Cues	States no pain	Whining, whimpering, moaning	Screaming, crying out	
Facial Cues	Relaxed, calm expression	Drawn around mouth and eyes	Facial frowning, wincing	
Positioning/guarding	Relaxes body	Guarding/tense fetal position	Jumped when touched	
Total Score				

Critical Care Observation Pain Tool (CPOT)			
This scale is used for the assessment of pain on the cognitively impaired patient and/or intubated patient. Attribute a score for each behavior and the rating should be the highest score observed during the observation period. The muscle tension should be evaluated last as the stimulation of touch when performing passive flexion and extension of the arm may lead to behavioral reactions.			
Indicator	Description	Brief Description	Score
Facial Expression	No muscular tension observed	Relaxed, neutral	0
	Presence of frowning, brow lowering, orbit tightening and levator contraction	Tense	1
	All of the above	Grimacing	2
Body Movements	Does not move at all (Does not necessarily mean absence of pain)	Absence of movements	0
	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements	Protection	1
	Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff. Trying to climb out of bed	Restlessness	2
** Muscle tension	No resistance to passive movements	Relaxed	0
	Resistance to passive movements	Tense, rigid	1
	Strong resistance to passive movements, inability to complete them	Very tense or rigid	2
	**Evaluation by passive flexion and extension of upper extremities		
Compliance with ventilator OR Vocalization (extubated patients)	Alarms not activated, easy ventilation	Tolerating vent or movement	0
	Alarms stop spontaneously	Coughing but tolerating	1
	Asynchrony: blocking ventilation, alarms frequently activated	Fighting ventilator	2
	OR	OR	OR
	Talking in normal tone or no sound	Talking in normal tone or no sound	0
	Sighing, moaning	Sighing, moaning	1
	Crying out, sobbing	Crying out, sobbing	2

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Pediatric Pain Scale (FLACC SCALE)			
This scale is used for assessment of pain in the pediatric population. This scale is multidimensional and assesses facial expressions, body movement, cry and response to handling/consolability. (age category 1 month to 16 years)			
Categories	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Unease, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to	Difficult to console or comfort
Each of the 5 categories are scored from 0 – 2, which results in a total score between 0 (no pain to 10 (worst pain)			

Neonatal Infant Pain Scale (NIPS)			
This scale is used for assessment of pain in the neonatal patient population. This scale is multidimensional and assesses facial expression, cry, breathing, body movements and state of arousal. (age category up to 1 month)			
Item	0	1	2
Facial Expression	Relaxed muscles, neutral expression	Tight facial muscles, furrowed brow, chin, jaw	
Cry	Quiet, not crying	Mild, moaning, intermittent cry	Loud scream, rising shrill, continuous
Breathing Pattern	Relaxed	Irregular, faster than normal, gagging, breath holding	
Arms	Relaxed, no muscular rigidity, occasional random movement of arms	Flexed/extended, tense straight arms, rigid, rapid extension and flexion	
Legs	Relaxed, no muscle rigidity, occasional random movement of legs	Flexed/extended, tense straight legs, rigid and/or rapid extension flexion	
State of Arousal	Sleeping/awake quiet, peaceful, alert and settled	Fussy, alert, restless and thrashing	
Interpretation of NIPS Scale:			
0 = no pain no intervention required			
1 – 2 = mild pain nonpharmacologic interventions indicated			
3 – 4 = moderate pain non pharmacologic interventions indicated			
5 – 7 = severe pain discuss pharmacological intervention with a physician to be used in addition tononpharmacologic measures			

Approved at President's Council meeting 2/1/2016